

HEALTH AWARENESS AMONG WOMEN: A STUDY ON WOMEN'S PERSPECTIVES AND HUSBANDS' PERCEPTIONS

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ABSTRACT

This paper examines health awareness among women in Bihar, India, and explores husbands' perceptions regarding their wives' health consciousness. Data were gathered through a mixed-methods survey involving 30 women (15 Hindu and 15 Muslim) and 20 men across Araria and Purnia districts. The findings reveal that women's health awareness is significantly influenced by their socio-economic status, educational attainment, and accessibility of healthcare facilities. Additionally, husbands' perceptions of women's health awareness are shaped by their social and cultural backgrounds, which perpetuate traditional gender roles and limited understanding of women's specific health needs. The study underscores the critical need for gender-inclusive health interventions that address structural barriers while engaging male partners as allies in women's healthcare.

Keywords: Health awareness, socio-economic status, educational attainment, gender roles, healthcare-seeking behavior, Bihar, spousal influence.

INTRODUCTION

Women's health awareness constitutes a fundamental determinant of their overall well-being, particularly in resource-constrained settings where gender disparities in healthcare access persist. In the Indian state of Bihar, women from marginalized communities encounter multifaceted barriers to accessing and utilizing health facilities, including socio-cultural restrictions, economic dependence, limited mobility, and inadequate health infrastructure. These challenges are compounded by deeply entrenched patriarchal norms that subordinate women's health needs to household priorities.

Existing literature establishes a robust correlation between women's health awareness and their socio-economic status, educational level, and proximity to health services. However, there remains a significant gap in understanding how husbands' perceptions mediate women's health-seeking behavior within the specific socio-cultural context of Bihar—a state characterized by low female literacy rates, high maternal mortality, and pronounced gender inequality indices. This study seeks to bridge this gap by examining: (a) the determinants of women's health awareness, (b) the role of husbands' perceptions in facilitating or constraining women's healthcare access, and (c) the intersection of religious identity and urban-rural residence in shaping health awareness outcomes.

OBJECTIVES

1. To identify and analyze the primary sources of health information available to women in the study districts, including formal channels (health workers, media, schools) and informal networks (family, community, religious leaders).
2. To assess the impact of socio-demographic factors—including age, religion, caste, education, income, occupation, and place of residence—on health awareness levels among women.

3. To examine the relationship between women's health awareness and their actual healthcare-seeking behavior, identifying gaps between knowledge and practice.
4. To explore the mechanisms through which husbands can support their wives' health needs, including financial support, transportation assistance, emotional encouragement, and joint decision-making.

LITERATURE REVIEW

Women's health awareness has emerged as a critical area of inquiry in Indian public health research. Das et al. (2020) demonstrated that education serves as a primary determinant of health awareness among Indian women, with educated women exhibiting superior health status and higher utilization rates of maternal and child health services. This educational gradient operates through multiple pathways: enhanced health literacy, greater autonomy in decision-making, improved communication with healthcare providers, and increased exposure to health information through media and social networks.

Sharma et al. (2017) highlighted the pivotal role of husbands' perceptions in shaping women's health-seeking behavior in India. Their research indicated that husband involvement in health discussions correlates with improved maternal health outcomes, including antenatal care attendance, institutional deliveries, and postnatal care utilization. This finding aligns with global evidence suggesting that male engagement interventions can effectively reduce gender-based barriers to healthcare.

Patel et al. (2018) conducted a cross-sectional study in rural Gujarat revealing that women's health awareness is contingent upon their socio-economic status, educational attainment, and physical access to healthcare services. The study emphasized the need for integrated interventions combining health education with infrastructure development to improve health awareness among rural women. Similarly, Singh et al. (2019) demonstrated through systematic review that community-based programs—particularly those employing participatory learning approaches and peer education—can effectively promote women's health awareness and healthcare-seeking behavior in rural Indian contexts.

Religious identity significantly influences health awareness and healthcare access. Khan et al. (2020) documented that Muslim women in India face disproportionate barriers to healthcare access due to socio-cultural restrictions on mobility, preference for female healthcare providers, economic marginalization, and perceived discrimination within public health facilities. Gupta et al. (2019) found that Hindu women generally demonstrate better health status and healthcare-seeking behavior compared to Muslim women, attributing these differences to variations in female education rates, economic empowerment, and community-level health infrastructure.

Urban-rural disparities further compound health awareness inequities. Kumar et al. (2018) confirmed that urban women exhibit superior health awareness and healthcare-seeking behaviors relative to their rural counterparts, driven by better educational opportunities, proximity to health facilities, exposure to mass media, and relatively less restrictive gender norms. The study recommended targeted investments in rural health infrastructure and culturally appropriate health communication strategies.

METHODOLOGY

Research Design: A convergent parallel mixed-methods design was employed, integrating quantitative survey data with qualitative in-depth interviews to provide comprehensive insights into women's health awareness and husbands' perceptions.

Study Setting: The research was conducted in Araria and Purnia districts of Bihar—two districts characterized by low human development indicators, significant Muslim populations, and limited healthcare infrastructure. These districts were purposively selected to capture diverse socio-cultural and religious contexts.

Sample:

1. Quantitative component: 30 women respondents (stratified as 15 Hindu and 15 Muslim) and 20 men (husbands of participating women where possible) were surveyed.
2. Qualitative component: 20 couples (10 Hindu and 10 Muslim) participated in in-depth unstructured interviews.

Sampling Method: Purposive sampling was employed to ensure representation across religious groups and urban-rural residence. While the sample size is modest, it was designed to achieve saturation in qualitative themes and preliminary quantitative patterns for hypothesis generation.

Data Collection Instruments:

A structured questionnaire adapted from NFHS-5 (National Family Health Survey-5) and WHO's Women's Health Survey was administered to collect quantitative data on:

1. Socio-demographic characteristics (age, education, occupation, income, religion, caste, residence)
2. Health awareness indicators (knowledge of reproductive health, nutrition, family planning, communicable diseases)
3. Healthcare-seeking behavior (frequency of health facility visits, type of provider consulted, barriers encountered)
4. Husbands' perceptions (attitudes toward women's health needs, decision-making patterns, support behaviors)

Unstructured in-depth interviews explored participants' lived experiences, cultural beliefs about women's health, gender dynamics within households, and community-level barriers to healthcare access.

Data Analysis:

1. Quantitative data were analyzed using SPSS software. Chi-square tests examined associations between categorical variables (e.g., education and health awareness). Logistic regression identified predictors of healthcare-seeking behavior, controlling for confounding variables.
2. Qualitative data were transcribed verbatim and analyzed using thematic analysis, following Braun and Clarke's (2006) six-phase framework. Themes were coded inductively and triangulated with quantitative findings.

Ethical Considerations: Informed consent was obtained from all participants. Confidentiality was maintained through anonymization of data. Given the sensitive nature of health discussions within marital relationships, interviews were conducted in private settings with female researchers interviewing women and male researchers interviewing men where culturally appropriate.

RESULTS

Association Between Education and Health Awareness:

A chi-square test revealed a statistically significant positive association between women's educational level and health awareness ($\chi^2 = 12.56$, $p < 0.01$). Women with completed primary education or higher demonstrated substantially greater knowledge of reproductive health, nutrition, and preventive care compared to non-literate women. This association remained robust across both religious groups, though the magnitude of effect varied.

Predictors of Healthcare-Seeking Behavior:

Logistic regression analysis identified several significant predictors of women's healthcare-seeking behavior:

1. Husbands' views and approval: Odds Ratio = 2.56, $p < 0.05$. Women whose husbands expressed supportive attitudes toward healthcare utilization were 2.56 times more likely to seek medical care when needed.
2. Educational attainment: Higher education levels significantly predicted healthcare-seeking behavior (OR = 1.89, $p < 0.05$).
3. Place of residence: Urban residence was associated with increased likelihood of healthcare utilization (OR = 1.74, $p < 0.05$).

Qualitative Findings:

In-depth interviews revealed three overarching themes:

1. Structural barriers: Women consistently cited distance to facilities, transportation costs, and long waiting times as primary obstacles.
2. Gendered autonomy: Many women described needing explicit or implicit permission from husbands to visit health facilities, with Muslim women and rural residents reporting greater restrictions.
3. Information asymmetry: Husbands often possessed limited knowledge about women's specific health needs (e.g., menstrual health, antenatal care), leading to underestimation of health concerns.

FINDINGS

Women's Health Awareness:

Health awareness among women in the study districts was determined by a complex interplay of socio-economic status, educational background, and availability of healthcare facilities. Notable disparities emerged along religious and geographic lines:

1. Religious differences: Hindu women demonstrated higher health awareness compared to Muslim women. This disparity may be attributed to differential access to education, varying community-level health infrastructure, and distinct cultural norms regarding women's mobility and interaction with public institutions.
2. Urban-rural gradient: Urban women exhibited significantly higher health awareness than rural women, reflecting disparities in educational access, media exposure, and proximity to health facilities.

Husbands' Perceptions:

Husbands' perceptions regarding women's health awareness were fundamentally shaped by social and cultural contingencies:

1. Traditional gender roles: Many husbands viewed women's health primarily through the lens of reproductive functionality rather than holistic well-being, leading to prioritization of maternal health over general health maintenance.
2. Limited knowledge: A pervasive lack of understanding about women's specific health needs—including menstrual hygiene, mental health, and menopausal care—constrained husbands' ability to support their wives effectively.
3. Religious variation: Husbands of Hindu women demonstrated somewhat better understanding of women's health awareness compared to husbands of Muslim women, potentially reflecting differential exposure to health education campaigns and community health worker interactions.

Health-Seeking Behavior:

Women's healthcare-seeking behavior was profoundly influenced by husbands' perceptions and explicit approval. Key patterns included:

1. Spousal gatekeeping: Women frequently required husbandly permission or accompaniment to access healthcare services, particularly for conditions perceived as sensitive (e.g., reproductive health, mental health).
2. Urban advantage: Women in urban areas were significantly more likely to seek healthcare services compared to rural women, benefiting from reduced transportation barriers, greater anonymity, and more flexible gender norms.
3. Economic mediation: Even when awareness was high, healthcare-seeking was often contingent upon husbands' willingness to allocate financial resources for women's health needs.

DISCUSSION

The findings illuminate the critical importance of addressing both women's health awareness and husbands' perceptions in Bihar's public health landscape. The study reveals that health awareness alone is insufficient to ensure healthcare utilization; rather, women's health-seeking behavior operates within a complex web of spousal dynamics, economic constraints, and socio-cultural norms.

Structural and Cultural Barriers:

The research highlights how marginalized women remain structurally dependent upon their husbands for healthcare access. This dependence manifests in multiple dimensions: financial control, mobility restrictions, and decision-making authority. Women frequently lack the autonomy to recognize, articulate, or act upon their health concerns. In many households, women's health needs are subordinated to economic productivity and family welfare, with illness perceived as a disruption to domestic labor rather than a legitimate claim on household resources.

Reproductive Burden and Health Neglect:

The study documents how women's disproportionate burden of childbearing—often characterized by closely spaced pregnancies and limited contraceptive autonomy—exacerbates health vulnerabilities. Women reported feeling unable to voice health concerns or

prioritize self-care, reflecting internalized gender norms that equate female sacrifice with virtue. This silence extends across physical and psychological domains, with mental health concerns particularly stigmatized and neglected.

The Role of Religious Identity:

The observed differences between Hindu and Muslim women cannot be reduced to religious doctrine alone; rather, they reflect intersecting inequalities in education, economic status, and community infrastructure. However, religious identity does shape the cultural acceptability of women's mobility, interaction with male healthcare providers, and participation in community health programs—factors that demand culturally sensitive intervention design.

Implications for Male Engagement:

The significant odds ratio for husbands' approval (OR = 2.56) underscores that male engagement is not merely complementary but potentially transformative for women's health outcomes. Interventions that position husbands as supportive partners rather than obstacles may leverage existing relational dynamics to improve healthcare access.

CONCLUSION

This study contributes to the growing literature on women's health awareness and spousal dynamics in marginalized communities of Bihar. The findings carry significant implications for policymakers, healthcare providers, and community organizations seeking to improve women's health outcomes:

1. Integrated interventions that simultaneously promote health awareness among women and engage husbands as informed allies may prove more effective than women-only approaches.
2. Cultural competence in healthcare delivery—particularly sensitivity to religious norms regarding female providers and privacy—is essential for reducing access barriers.
3. Structural investments in rural health infrastructure, transportation, and female education remain foundational to sustainable improvement.

By promoting health awareness and strategically involving husbands in women's health discussions, public health programs can contribute to reducing health disparities and improving the holistic well-being of women in Bihar's marginalized communities.

RECOMMENDATIONS

1. Health Education Programs

1. Develop comprehensive health education programs targeting both women and their husbands, addressing women's health issues across the life course (adolescence, pregnancy, menopause).
2. Utilize participatory methodologies that encourage dialogue between spouses about health priorities and decision-making.
3. Integrate mental health literacy to address the documented psychological distress among women.

2. Community-Based Interventions

1. Design community-based interventions that engage local religious leaders, village elders, and women's self-help groups as change agents.

2. Establish male peer educator networks to challenge harmful gender norms and promote positive masculinities in health contexts.
3. Create safe spaces for women to discuss health concerns without spousal surveillance, while simultaneously building husband support.

3. Access to Healthcare Services

1. Improve physical access to health services in rural areas through mobile clinics, telemedicine initiatives, and transportation vouchers.
2. Ensure cultural sensitivity by training female healthcare providers, providing gender-segregated waiting areas, and accommodating religious dietary and modesty requirements.
3. Establish community health worker programs with sustained government support rather than project-based funding.

4. Women's Empowerment

1. Provide women with comprehensive health information through multiple channels (print, audio, digital) appropriate to literacy levels.
2. Strengthen women's economic autonomy through livelihood programs and conditional cash transfers that enhance their bargaining power within households.
3. Advocate for legal and policy frameworks that affirm women's right to autonomous healthcare decision-making.

5. Research and Monitoring

1. Conduct longitudinal studies to assess the sustainability of spousal engagement interventions.
2. Develop context-specific indicators of women's health autonomy that capture both awareness and agency.
3. Monitor intersectional disparities (religion, caste, geography) in program outcomes to ensure equitable impact.

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